

TO BE GIVEN TO PERSON
EXAMINED WITH A PRE-
ADDRESSED "CONFIDEN-
TIAL-MEDICAL" ENVELOPE.

UNITED STATES CIVIL SERVICE COMMISSION
CERTIFICATE OF MEDICAL EXAMINATION

Form Approved
Budget Bureau
No. 50-R0073

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)

1. NAME (last, first, middle)	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. DATE OF BIRTH
5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? <input type="checkbox"/> YES <input type="checkbox"/> NO (If your answer is YES, explain fully to the physician performing the examination)		6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. (Signature of applicant)	

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION <input type="checkbox"/> PREAPPOINTMENT <input type="checkbox"/> OTHER (Specify)	2. POSITION TITLE																																																																								
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO																																																																									
4. Circle the number preceding each functional requirement and each environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attached the specific medical standards for the information of the examining physician. A. FUNCTIONAL REQUIREMENTS <table border="0"><tr><td>1. Heavy lifting, 45 pounds and over</td><td>15. Crawling (hours)</td><td>25. Far vision correctable in one eye to 20/20 and to 20/40 in the other</td></tr><tr><td>2. Moderate lifting, 15-44 pounds</td><td>16. Kneeling (hours)</td><td>26. Far vision correctable in one eye to 20/50 and to 20/100 in the other</td></tr><tr><td>3. Light lifting, under 15 pounds</td><td>17. Repeated bending (hours)</td><td>27. Specific visual requirement (specify)</td></tr><tr><td>4. Heavy carrying, 45 pounds and over</td><td>18. Climbing, legs only (hours)</td><td>28. Both eyes required</td></tr><tr><td>5. Moderate carrying, 15-44 pounds</td><td>19. Climbing, use of legs and arms</td><td>29. Depth perception</td></tr><tr><td>6. Light carrying, 15-44 pounds</td><td>20. Both legs required</td><td>30. Ability to distinguish basic colors</td></tr><tr><td>7. Straight pulling (hours)</td><td>21. Operation of crane, truck, tractor, or motor vehicle</td><td>31. Ability to distinguish shades of colors</td></tr><tr><td>8. Pulling hand over hand (hours)</td><td>22. Ability for rapid mental and muscular coordination simultaneously</td><td>32. Hearing (aid permitted)</td></tr><tr><td>9. Pushing (hours)</td><td>23. Ability to use and desirability of using firearms</td><td>33. Hearing without aid</td></tr><tr><td>10. Reaching above shoulder</td><td>24. Near vision correctable at 13" to 16" to Jaeger 1 to 4</td><td>34. Specific hearing requirements (specify)</td></tr><tr><td>11. Use of fingers</td><td></td><td>35. Other (specify)</td></tr><tr><td>12. Both hands required</td><td></td><td></td></tr><tr><td>13. Walking (hours)</td><td></td><td></td></tr><tr><td>14. Standing (hours)</td><td></td><td></td></tr></table> B. ENVIRONMENTAL FACTORS <table border="0"><tr><td>1. Outside</td><td>11. Silica, asbestos, etc.</td><td>20. Working on ladders or scaffolding</td></tr><tr><td>2. Outside and inside</td><td>12. Fumes, smoke, or gases</td><td>21. Working below ground</td></tr><tr><td>3. Excessive heat</td><td>13. Solvents (degreasing agents)</td><td>22. Unusual fatigue factors (specify)</td></tr><tr><td>4. Excessive cold</td><td>14. Grease and oils</td><td>23. Working with hands in water</td></tr><tr><td>5. Excessive humidity</td><td>15. Radiant energy</td><td>24. Explosives</td></tr><tr><td>6. Excessive dampness or chilling</td><td>16. Electrical energy</td><td>25. Vibration</td></tr><tr><td>7. Dry atmospheric conditions</td><td>17. Slippery or uneven walking surfaces</td><td>26. Working closely with others</td></tr><tr><td>8. Excessive noise, intermittent</td><td>18. Working around machinery with moving parts</td><td>27. Working alone</td></tr><tr><td>9. Constant noise</td><td>19. Working around moving objects or vehicles</td><td>28. Protracted or irregular hours of work</td></tr><tr><td>10. Dust</td><td></td><td>29. Other (specify)</td></tr></table>		1. Heavy lifting, 45 pounds and over	15. Crawling (hours)	25. Far vision correctable in one eye to 20/20 and to 20/40 in the other	2. Moderate lifting, 15-44 pounds	16. Kneeling (hours)	26. Far vision correctable in one eye to 20/50 and to 20/100 in the other	3. Light lifting, under 15 pounds	17. Repeated bending (hours)	27. Specific visual requirement (specify)	4. Heavy carrying, 45 pounds and over	18. Climbing, legs only (hours)	28. Both eyes required	5. Moderate carrying, 15-44 pounds	19. Climbing, use of legs and arms	29. Depth perception	6. Light carrying, 15-44 pounds	20. Both legs required	30. Ability to distinguish basic colors	7. 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Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME (Type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN (Signature) (Date)
2. ADDRESS (Including ZIP Code)	IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take these, and the brief description of the job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: _____ FEET, _____ INCHES. WEIGHT: _____ POUNDS.

1. EYES: _____ 20 _____ 20 _____ 20 _____ 20

(A) Distant vision (Snellen): without glasses: right _____ left _____ ; with glasses, if worn; right _____ left _____

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant?
Test each eye separately.

_____ Jaeger No. 2 Type _____

employees in the Federal classified service as may be required by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

without glasses:

{

L _____ in. to _____ in.

R _____ in. to _____ in.

with glasses, if used:

L _____ in. to _____ in.

R _____ in. to _____ in.

(B) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO
If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
Ordinary conversation: _____

Audiometer (if given):

RIGHT EAR _____ ; LEFT EAR _____
20 ft. 20 ft.

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through i briefly describe any abnormality (including diseases, scars, and disfigurements). Include brief history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat (including tooth and oral hygiene)

e. Abdomen

b. Head and back (including face, hair, and scalp)

f. Peripheral blood vessels

c. Speech (note any malfunction)

g. Extremities

d. Skin and lymph nodes (including thyroid gland)

h. Urinalysis (if indicated)

Sp. gr. _____ Sugar _____ Blood _____
Albumen _____ Casts _____ Pus _____

i. Respiratory tract (X-ray if indicated)

j. Heart (size, rate, rhythm, function)

Blood pressure _____
Pulse _____
EKG (if indicated) _____

k. Back (special consideration for positions involving heavy lifting and other strenuous duties)

l. Neurological and mental Health

Jaeger No. 2 Type

Conclusions: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

- ☐ No limiting conditions for this job
☐ Limiting conditions as follows

FOR AGENCY USE ONLY

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. NAME (<i>last, first, middle</i>)	2. SOCIAL SECURITY ACCOUNT NO. <div style="border-bottom: 1px solid black; width: 100%;"></div>	3. SEX <div style="border: 1px solid black; width: 100%; height: 20px; display: flex; align-items: center; justify-content: center;"><div style="width: 10px; height: 10px; border: 1px solid black; margin-right: 5px;"></div>MALE FEMALE</div>	4. DATE OF BIRTH
5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? <div style="display: flex; justify-content: space-around; margin-top: 5px;"><div><input type="checkbox"/> YES</div><div><input type="checkbox"/> NO</div></div> <small>(If your answer is YES, explain fully to the physician performing the examination)</small>	6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. <div style="border-top: 1px solid black; width: 100%; margin-top: 10px; text-align: center;"><i>(Signature of applicant)</i></div>		

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (*if one is available*)

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.

1. RECOMMENDATION: <div style="margin-top: 10px;"><input type="checkbox"/> HIRE OR RETAIN, DESCRIBE LIMITATIONS, IF ANY, HERE.</div> <div style="margin-top: 40px;"><input type="checkbox"/> TAKE ACTION TO SEPARATE OR DO NOT HIRE, EXPLAIN WHY</div>		
2. AGENCY MEDICAL OFFICER'S NAME (<i>type or print</i>)	3. LOCATION (<i>city, State, ZIP Code</i>)	4. DATE

Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in part F is circled. **IMPORTANT:** See FPM Chapter 293, Subchapter 3; FPM Chapter 339; and FPM Supplement 339-31 for disposition and/or filing of both parts of this form, either separately or together.

1. ACTION TAKEN: <div style="display: flex; justify-content: space-between; margin-top: 5px;"><div><input type="checkbox"/> HIRED OR RETAINED</div><div><input type="checkbox"/> NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO.</div></div> <div style="margin-top: 5px;"><input type="checkbox"/> ACTION TAKEN TO SEPARATE</div>		
2. AGENCY PERSONNEL OFFICER'S NAME (<i>Type or print</i>)	3. SIGNATURE	4. DATE

Part F. HANDICAP CODE (*to be completed only in pre-appointment cases*)

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

- | | | |
|---|---|--|
| 00 No handicap of the type listed | 40 Hearing aid required | 52 Diabetes-controlled |
| 10 Amputations-one major extremity | 41 No usable hearing | 53 Epilepsy-adequately controlled |
| 11 Amputation-two or more major extremities | 42 No usable hearing, with speech malfunction | 54 History of emotional behavioral problems requiring special placement effort |
| 20 Deformity or impaired function-upper extremity | 43 Normal hearing, with speech malfunction | 55 Mentally retarded |
| 21 Deformity or impaired function-lower extremity or back | 50 Tuberculosis-inactive pulmonary | 56 Mentally restored |
| 30 Vision-one eye only | 51 Organic heart disease (<i>compensated</i>)-Valvular, arrhythmia, arteriosclerosis, healed coronary lesions | |
| 31 No usable vision | | |

1. EXAMINING PHYSICIAN'S NAME (<i>type or print</i>)	3. SIGNATURE OF EXAMINING PHYSICIAN <div style="border-top: 1px solid black; width: 100%; margin-top: 10px; display: flex; justify-content: space-between;"><div><i>(signature)</i></div><div><i>(date)</i></div></div>
2. ADDRESS (including ZIP Code)	IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.